

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155295		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/02/2012	
NAME OF PROVIDER OR SUPPLIER CLINTON HOUSE HEALTH AND REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 809 W FREEMAN ST FRANKFORT, IN 46041			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0000	<p>This visit was for the Investigation of Complaints IN00115972 and IN00116852.</p> <p>Complaint IN00115972 - Substantiated. Federal/state deficiencies related to the allegations are cited at F 465.</p> <p>Complaint IN00116852 - Substantiated. Federal/state deficiencies related to the allegation are cited at F 465.</p> <p>Survey dates: October 1, 2, 2012</p> <p>Facility number: 000192 Provider number: 155295 AIM number: 100291120</p> <p>Survey team: Tammy Alley, R.N. Toni Maley, B.S.W.</p> <p>Census bed type: SNF/NF: 65 Total: 65</p> <p>Census payor type: Medicare: 5 Medicaid: 52 Other: 8 Total: 65</p>		F0000	<p>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>Sample: 8</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on October 3, 2012 by Bev Faulkner, RN</p>						

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F0465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure resident room (Resident C) floors, doors and wheelchairs (Resident E and F) were clean, sanitary and in good repair. This deficient practice had the potential to affect 65 of 65 residents residing in the facility.</p> <p>Findings include:</p> <p>1. During the initial tour of the facility on 10/1/12 at 9:20 a.m., Resident C had a large trash can with a red bag inside sitting beside his bedside table. The trash can was over half full of trash and no lid was present. There was an alcohol prep pad and a clear syringe cap on the floor by the trash can. There was an Intravenous (IV) pole at the foot of the Resident C's bed and on the floor by the pole was a blue IV tubing cap. The cove board in the room had a build up of debris and the cove board was pulling away from the wall by the bathroom. There was a soiled cotton ball on the bathroom floor. During this time, Resident C indicated his room was not clean and the large trash can smelled bad.</p>		F0465	<p>F465 I. No negative outcome was identified through observation or assessment for the alleged deficient practice. II. All residents have the potential to be affected by the alleged deficient practice. All areas identified have been assessed and cleaned by nursing and the housekeeping staff. III. Housekeeping Supervisor will audit 25 % of the building during each audit. Also, 25% of the audits, for the periods below will occur on the weekend. For the first month they will complete an audit tool four times per week, twice a week for 3 months and once a week for 2 months to ensure proper cleaning has been established. Wheelchairs are on a routine cleaning schedule. Nurse Managers will audit 25 % of the building during each audit. Also, 25% of the audits will occur on the weekend. For the first month they will complete an audit tool four times per week, twice a week for 3 months and once a week for 2 months to ensure proper cleaning and has been established. Reeducation for staff will occur to include infection control, dignity and general cleanliness. Staff non-compliance will be addressed</p>		10/19/2012	

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	<p>On 10/2/12 at 8:30 a.m., Resident C's room was observed to have 3 alcohol prep pad wrappers, one alcohol prep pad, an IV cap and a M & M candy wrapper on the floor beside the bedside table. The large trash can with the red liner was not present. There was an alcohol prep pad wrapper on the floor by the IV pole at the foot of the bed.</p> <p>On 10/2/12 at 8:50 a.m. LPN # 1 was informed of the condition of the Resident C's floor. At that time during interview, she indicated the nurse's should do a better job of putting items in the trash can.</p> <p>On 10/2/12 at 11 a.m., the Assistant Director of Nursing indicated the large trash can with the red liner should not have been kept in Resident C's room. She indicated the resident was not in isolation and the trash can was to be utilized only during wound care.</p> <p>2. During the initial tour on 10/2/12 at 9:20 a.m., the following was observed.</p> <p>Room 412 had debris on the floor along with several brown spots.</p> <p>The following rooms had a build up of gray debris under the wax at the door</p>			<p>with 1:1 education and progressive disciplinary action as deemed appropriate. IV. Results will be reviewed in QA meeting monthly x 6 months and then quarterly with subsequent plan development and implementation as appropriate.</p>			

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	<p>frame of the entry room door:</p> <p>400 hall (12 rooms)</p> <p>main dietary door</p> <p>500 hall soiled and clean utility rooms</p> <p>Rooms 508, 512, 517. 700, 707, 711, 712, 709</p> <p>700 exit door to patio</p> <p>All the tile floors in the hallways were dull and lacked luster.</p> <p>The 400, 200, 500, and 600 hall fire doors had cob webs and debris and dust on the corners and behind the doors.</p> <p>There was a dark dried spill between Room 511 and Room 513.</p> <p>There was dried, dark spillage and foot prints on the floor outside the 500/600 and 200/400 hall nurses station.</p> <p>There was a dried, dark spillage area at the entry way of the facility.</p> <p>Resident E's wheelchair was observed on 10/1/12 at 11:30 a.m., to be soiled with dust on the base and wheels. There was also light brown spots of dried liquid on the lateral sides of the wheelchair and on the wheels.</p> <p>Resident F's wheelchair was observed on 10/1/12 at 11:50 .a.m., to be soiled with</p>						

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	<p>dust and light brown splatters on the base, wheels and lateral sides.</p> <p>During an interview on 10/2/12 at 11 a.m., the Administrator indicated he had checked the noted wheel chairs and they were not clean. He indicated night shift should clean the wheelchairs and they should also be checked on the resident's shower day for cleanliness. He also indicated the entry way floors had debris under the wax.</p> <p>This Federal tag relates to Complaints IN00115972 and IN00116852.</p> <p>3.1-19(f)</p>						